STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING _____ B. WING _____	C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	**2300 GREAT LAKES DR DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00189051 and Complaint IN00190136. This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/20/2015. This visit included the PSR to the Investigation of Complaint IN00186499. This visit was in conjunction with the PSR to the Investigation of Complaint IN00187603 completed on 12/1/15. Complaint IN00189051-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00190136-Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 13, 14, and 15, 2016. Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census bed type: SNF/NF: 98 Total: 98 Census payor type: Medicare: 16 Medicaid: 58 Other: 24 Total: 98 Kindred Transitional Care and Rehabilitation was found to be in compliance with 410 IAC 16.2-3.1	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	**2300 GREAT LAKES DR DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 in regard to the Investigation of Complaints IN00189051 and IN00190136. Quality review completed by 26143, on January 21, 2016.	F 000		